

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10152

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, R.D. c. LENGTH OF STAY IN 1b All life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun, R.D. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Willard Middle Nelson Last Barrow		4. DATE OF DEATH Month 9 Day 1 Year 19 60	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-2-1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Machine Op.		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Randel Barrow		14. MOTHER'S MAIDEN NAME Rachel Devonshire	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 172-05-6946	
17. INFORMATION Address Mrs. Estella Barrow, Rising Sun, R.D. 2, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Arterio Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER R.C. Dodson ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-4-60 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-5-60	22c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.	22d. LOCATION (City, town, or country) (State) Lancaster, Pa.
23. FUNERAL DIRECTOR Wm E M Miller		24. REC'D BY REGISTRAR Rising Sun Md. DATE SEP 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10198

CERTIFICATE OF DEATH

10153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clifton Mark Manor, Wilmington 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ewing Nursing Home		d. STREET ADDRESS 45 Central Terrace, Apt. #1	
3. NAME OF DECEASED (Type or print) First Maud Middle E. Last Beugless		4. DATE OF DEATH Month September Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1886
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chalkley J. Beugless		14. MOTHER'S MAIDEN NAME Anna R. Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. George W. Beeson		Address 45 Central Terrace Clifton Park Manor Wilm., Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric thrombosis 433.1 DUE TO (b) Multiple embolic phenomena DUE TO (c) auricular Fibrillation CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOLING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/8 , 19 60 , to 9/15 , 19 60 , that I last saw the deceased alive on 9/15 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Neil Taylor M.D.		ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 9/15/60	
PHYSICIAN'S NAME (Type) Neil Taylor Jr		Rising Sun, Md 9/15/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-19-60	22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery	22d. LOCATION (City, town, or county) (State) Wilmington, Del.
23. FUNERAL DIRECTOR'S SIGNATURE Edward S. Thomas		24a. REC'D BY REGISTRAR DATE SEP 21 '60	
ADDRESS Wilmington, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

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10179

CERTIFICATE OF DEATH

Reg. Dist. No. 10154

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle WILLIAM Last BLACK		4. DATE OF DEATH Month Sept. Day 18 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1937
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Elec. Hose & Rubber, Lansing, N. C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ira T. Black		14. MOTHER'S MAIDEN NAME Martha Woods	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 241-56-3042	
INFORMANT Address Mrs. Barbara H. Black, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embryonal carcinoma of the testicle with metastases to the lungs and brain DUE TO metastases to the lungs and brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 14 months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 59 to Sept. 18 60 , that I last saw the deceased alive on Sept. 18 60 , and that death occurred at 11:15 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 9/18/60 ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. PHYSICIAN'S NAME (Type) S. RALPH ANDREWS, JR., M.D. Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-20-60	22c. NAME OF CEMETERY OR CREMATORY Black Family Cemetery Warrensville, N. C.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR SEP 20 1960	24b. REGISTRAR'S SIGNATURE Arthur A. [Signature]

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CONFIDENTIAL

SECRET

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

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10155

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PERRY POINT		c. LENGTH OF STAY IN lb 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHILDS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS Not known		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLIFFORD Middle E. Last BURKINS				4. DATE OF DEATH Month September Day 8 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 7, 1902	
				9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer, retired		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK BURKINS				14. MOTHER'S MAIDEN NAME MARY DAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-2		16. SOCIAL SECURITY NO. 221 18 4102		17. INFORMANT Ernest Burkins (B) 230 N. Franklin St., Wilmington, Delaware.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible cardiac arrhythmia & or infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Rheumatic heart disease autonic generalized cardomegely. DUE TO (c) Physiologic: Congestive heart failure.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subacute bacterial endocarditis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (✓) (this hospital) attended the deceased from August 18, 19 60 to September 8, 19 60 that (✓) (we) last saw the deceased alive on Sept. 8, 1960 and that death occurred at 2:45 PM from the causes and on the date stated above.							
22a. SIGNATURE <i>Josefina C. Rodriguez</i> 22c. PHYSICIAN'S NAME (Type) JOSEFINA C. RODRIGUEZ, M.D.				22b. DATE SIGNED 9-8-60			
22d. ADDRESS VAH., Perry Point, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-8-60		23c. NAME OF CEMETERY OR CREMATORY Cherry Hill		23d. LOCATION (City, town, or county) (State) Cherry Hill, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME,				ADDRESS Elkton, Maryland		25a. REC'D BY REGISTRAR DATE SEP 15 '60	
				25b. REGISTRAR'S SIGNATURE <i>Charles S. Kline</i>			

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10180

CERTIFICATE OF DEATH

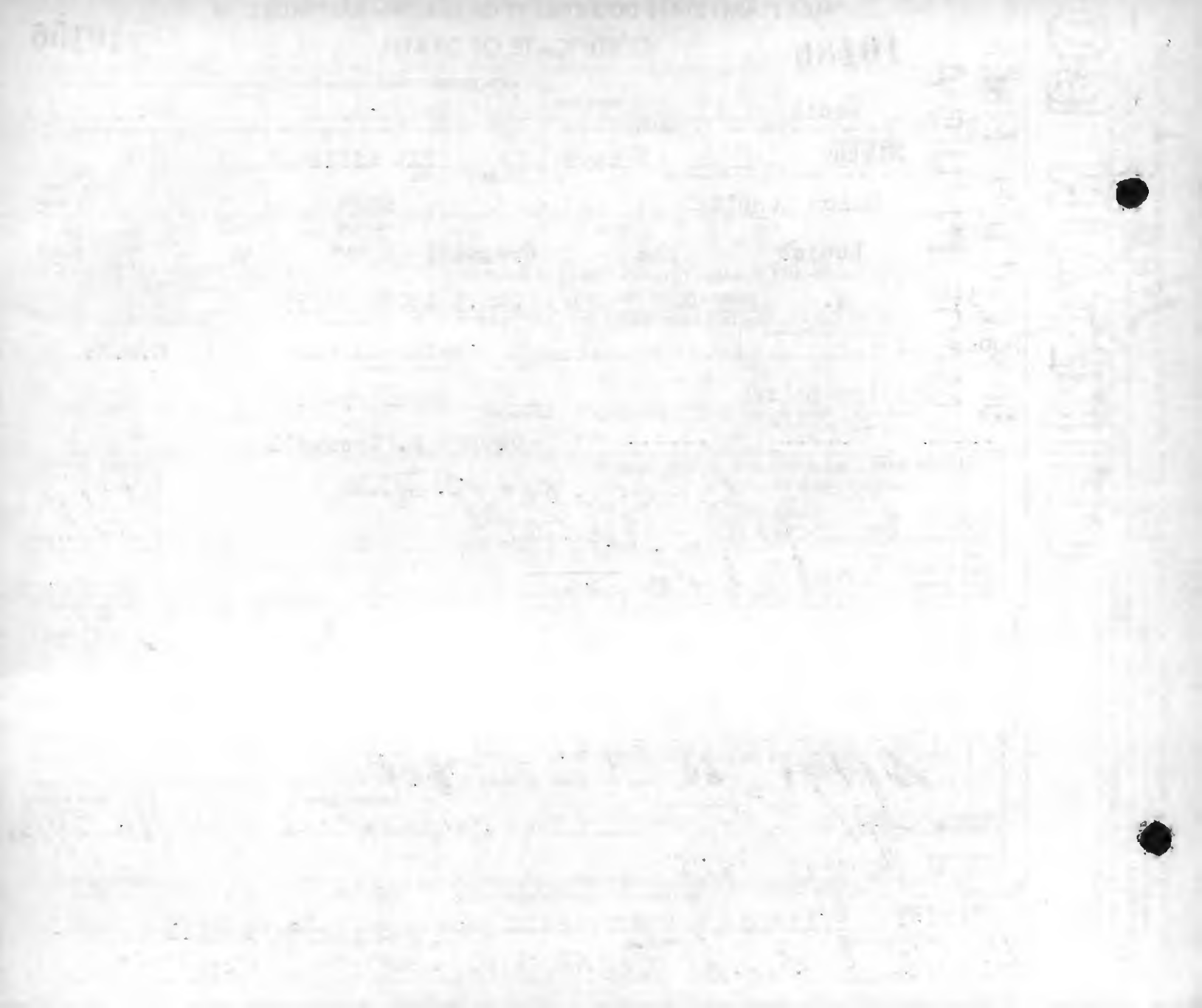
Reg. Dist. No.

10156

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Mills	
		d. STREET ADDRESS Rd #4	
3. NAME OF DECEASED (Type or print) First Louise Middle Mae Last Creswell		4. DATE OF DEATH Month 9 Day 7 Year 1960	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5 1925
9. AGE (In years lost birthday) yrs. 35		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Newark Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Bolton		14. MOTHER'S MAIDEN NAME Hazel Ryan.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ----- (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. -----	
INFORMANT George E. Creswell		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senile deg. art. peritonitis 585X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Cholecystitis DUE TO (c) Cholecystitis		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1 , 19 60 , to Sept 7 , 19 60 , that I last saw the deceased alive on Sept 7 , 19 60 , and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Davis		ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD	
PHYSICIAN'S NAME (Type) HENRY V. DAVIS		DATE SIGNED 9/9/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/11/60	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cherry Hill Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter In Box Jr.		24a. REC'D BY REGISTRAR DATE SEP 14 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10194

Item 4 10194-1 9-20-1960 et

CERTIFICATE OF DEATH

Reg. Dist. No.

10157

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mabel Middle E. Last Demond				4. DATE OF DEATH Month 9 Day 7 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1902		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North East Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Hines				14. MOTHER'S MAIDEN NAME Albertha Lilley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Ulysses G. Demond 111		Address North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion with myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 mos. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1958 to 7 Sept 1960, that I last saw the deceased alive on 5 Sept 1960, and that death occurred at 4 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner		M.D.		ADDRESS (Street, city or town, state) North East, Md		DATE SIGNED 9 Sept '60	
HYDROLYZING'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-1960		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE SEP 13 '60	
				24b. REGISTRAR'S SIGNATURE Clinton S. Hanna			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10158 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10158

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN TB <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital of Cecil County</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Principio</u> d. STREET ADDRESS <u>X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wrightson Thomas Dill</u>		4. DATE OF DEATH <u>Sept. 23 19 60</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/18/1913</u> 9. AGE (In years last birthday) <u>46</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u> 11. BIRTHPLACE (State or foreign country) <u>Newark, Del.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Wrightson Dill</u> 14. MOTHER'S MAIDEN NAME <u>Ella Dill</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>222-01-2395</u> 17. INFORMANT <u>Mrs. Wrightson T. Dill</u> Address <u>Principio, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Occute Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D. EXAMINER'S NAME (Type) <u>R.C. Dodson</u> Address (Street, city, town, or county) _____ 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>9/27/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Newark Cem.</u> 22d. LOCATION (City, town, or country) <u>Newark, Delaware</u> (State) _____ 23. FUNERAL DIRECTOR <u>R.T. Jones</u> Address <u>Newark, Delaware</u> 24a. REC'D BY REGISTRAR <u>SEP 28 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kimes</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10159

10182

FOR STATE HEALTH DEPT

M

1. PLACE OF DEATH

a. COUNTY

Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Elkton

MARYLAND

c. LENGTH OF STAY IN

15 hours

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Union Hospital

3. NAME OF DECEASED

(Type or print)

Gertrude Dillard

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED

☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

4-6-1911

9. AGE (In years last birthday)

49 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Same

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Walter F. Manuel

14. MOTHER'S MAIDEN NAME

Lillian Pearson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

=====

17. INFORMANT

James Dillard, 2523 14th St. N.W.

Address Washington, D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Hemorrhagic Pancreatitis

DUE TO

Fatty Liver.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year

19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

R.C. Dodson

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

9-22-60

EXAMINER'S NAME (Type)

R.C. Dodson

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

9/26/60

22c. NAME OF CEMETERY OR CREMATORY

Fort Lincoln Cem

22d. LOCATION (City, town, or county)

Calmar Manor Md

(State)

23. FUNERAL DIRECTOR

De Witt Donaldson Laurel Md

ADDRESS

24a. REC'D BY REGISTRAR

DATE SEP 28 '60

24b. REGISTRAR'S SIGNATURE

Carlton S. Harris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1 should be executed and the certificate "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

19200

10160

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE New Jersey b. COUNTY Atlantic	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Margate City	
c. LENGTH OF STAY IN 1b 18yrs7mos17days		d. STREET ADDRESS 108 N. Pembroke Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATHRYN Middle E. Last ELDRIDGE		4. DATE OF DEATH Month September Day 28 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1897
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Telephone	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archibald S. Lambert		14. MOTHER'S MAIDEN NAME Kathryn E. Knox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Leoma Steelman (sister)		Address 108 N. Pembroke Ave., Margate City, N.J.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 601X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis DUE TO (c) Hydronephrosis with renal calculi		INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis w/Meningo vascular luetic disease.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Febr. 11, 1942 to Sept. 28, 1960 , that (we) last saw the deceased alive on Sept. 28, 1960 , and that death occurred at 1:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Albert L. Mooney		22b. DATE SIGNED Sept. 28, 1960	
22c. PHYSICIAN'S NAME (Type) ALBERT L. MOONEY, M.D.		22d. ADDRESS VA Hospital, Perry Point, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/29/1960	
23c. NAME OF CEMETERY OR CREMATORY Laurel Memorial		23d. LOCATION (City, town, or county) (State) Atlantic City, N.J.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. H. & Son		24a. REC'D BY REGISTRAR SEP 30 '60	
24b. ADDRESS Havre DeGrace, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10161

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 7/59

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 15 2mos. 17days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 729 N. Capitol Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First (NMI) Middle FORD Last		4. DATE OF DEATH Month September 24 Day 19 Year 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH November 24, 1893	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66	
11. IF UNDER 24 HRS. Hours 66 Min. 66		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Handler, retired		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Ford (Deceased)		14. MOTHER'S MAIDEN NAME Nellie LaRoque	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-1		16. SOC. AL SECURITY NO. 578-07-9680	
17. INFORMANT VA Hospital, Perry Point, Md. records.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus 539.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Post operative for stricture of the Esophagus. DUE TO (c) Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. DODSON EXAMINER'S NAME (Type) R. C. DODSON, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9-24-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 9/29/60	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. ADDRESS Kennerly Pm Hmds Care Md.	
23. FUNERAL DIRECTOR Kennerly Pm Hmds Care Md.		24a. REC'D BY REGISTRAR DATE SEP 30 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10183

CERTIFICATE OF DEATH

Reg. Dist. No.

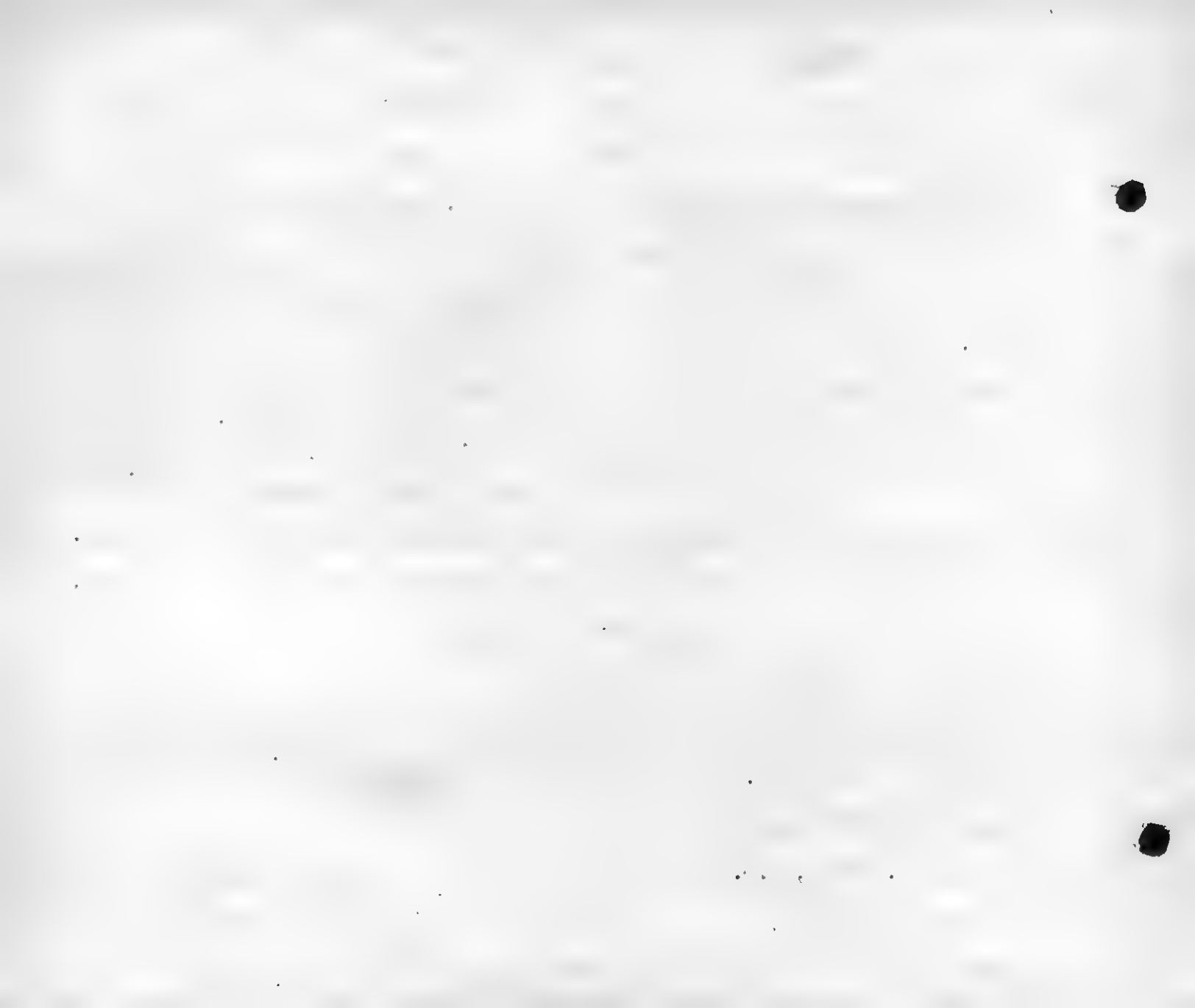
10162

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Galena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS Galena	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First J. Middle Earle Last Gilfillan		4. DATE OF DEATH Month September Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August, 11, 1887
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY Doctor	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joel C. Gilfillan		14. MOTHER'S MAIDEN NAME Edna Darlington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes. (If yes, give war or dates of service) W.W. I		16. SOCIAL SECURITY NO. W.W. I	
17. INFORMANT Mrs. Jennie S. Gilfillan,		Address Galena, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Arterio sclerotic Heart Disease, Nephrosis (in remission)		INTERVAL BETWEEN ONSET AND DEATH 5 days. years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio sclerotic Heart Disease, Nephrosis (in remission)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 15, 1960 to Sept 12, 1960 , that I last saw the deceased alive on Sept 12 , 19 60 , and that death occurred at 4:58 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 14 Sept 60	
ACTUAL SIGNATURE Wallace Obenshain M.D.			
PHYSICIAN'S NAME (Type) Wallace Obenshain		Cecilton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 15, 1960	
22c. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park.		22d. LOCATION (City, town, or county) (State) Wilmington, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Wilmington, Md.		24a. REC'D BY REGISTRAR DATE SEP 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Krumm			

1
M
TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10202
M
10163
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 50 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1310 S. Randolph Street	
3. NAME OF DECEASED (Type or print) SAMUEL G. HENDRICK		4. DATE OF DEATH Month 9 Day 8 Year 1960	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/95
9 AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min 65	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto. Repairman		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Hendrick		14. MOTHER'S MAIDEN NAME Elizabeth Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 224-05-3197	
17 INFORMANT Robert L. Hendrick		1310 S. Randolph Street Arlington, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarcts of unknown etiology DUE TO Hypertensive cardio vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis, generalized severe DUE TO Unkn. DUE TO Unkn. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Basal cell carcinoma of nose		INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that xx (this hospital) attended the deceased from July 20 1960, to Sept. 8 1960, that x (we) last saw the deceased alive on Sept. 8 1960, and that death occurred 7:25 PM from the causes and on the date stated above.			
22a. SIGNATURE J. L. Garey PHYSICIAN'S NAME (Type) JAMES L. GAREY, M.D.		22b. ADDRESS VAH, Perry Point, Maryland	
22c. DATE Sept. 13, 1960		22d. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.	
22e. LOCATION (City, town, or county) (State) Arlington, Va.		22f. DATE SEP 13 '60	
24 FUNERAL DIRECTOR'S SIGNATURE Green Funeral Home, Herndon, Virginia		25a. REC'D BY REGISTRAR C. L. S. Kenna	
25b. REGISTRAR'S SIGNATURE C. L. S. Kenna		25c. DATE SEP 13 '60	



DEPUTY FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or other person authorized by the hospital or attending physician, may be retained by the funeral director to prepare the body for burial. The certificate should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10195

10164

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		2. USUAL RESIDENCE (Where deceased lived. If institution, give nearest town) a. STATE Maryland b. COUNTY Cecil	
c. LENGTH OF STAY IN IB Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 48 S. Main St.		d. STREET ADDRESS 48 S. Main St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Albert Last Hohn		4. DATE OF DEATH Month Sept. Day 3 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1885
9. AGE (in years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
11. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Post Master		10b. KIND OF BUSINESS OR INDUSTRY U.S. P.O.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Hohn		14. MOTHER'S MAIDEN NAME Cora Brumfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO NO	
17. INFORMANT Florence J. Hohn, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Relapsing Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Relapsing Emphysema (c) Relapsing Emphysema INTERVAL BETWEEN ONSET AND DEATH 12 hrs 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10, 1946 to Sept 3, 1960 . that (I) (we) lost the deceased alive on Sept 2, 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE G.H. Richards Jr.		22b. DATE SIGNED 9/3/60	
22c. PHYSICIAN'S NAME (Type) G.H. Richards Jr.		22d. ADDRESS Port Deposit, Md.	
23a. BURIAL, CREMATION, or OTHER DISPOSITION Burial		23b. DATE THEREOF 9-6-1960	
23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Wesley Patterson & Son		25a. REC'D BY REGISTRAR DATE SEP 6 1960	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna		25c. ADDRESS Perryville, Md.	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
10203														
10165														
CERTIFICATE OF DEATH														
1 PLACE OF DEATH a. COUNTY Cecil MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution Residence before adm ssion) a. STATE Maryland b. COUNTY									
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point					c LENGTH OF STAY IN 1b 2yrs 2mo 9days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital					d. STREET ADDRESS 3815 Park Heights Ave.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Simon Klein					4. DATE OF DEATH Month Day Year Sept 9 1960									
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-17-95		9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Clerical VA				11. BIRTHPLACE (State or foreign country) Washington, D.C. MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Hyman Klein					14. MOTHER'S MAIDEN NAME Not ascertainable									
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes no, or unknown) Yes		(If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO Unknown		17. INFORMANT 202-14 address 104 Ave Samuel P.Klein (B) Hollis 12, N.Y.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular Fibrillation 7200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart Disease, severe DUE TO (c) Arteriosclerosis, generalized, severe PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus and Essential Hypertension INTERVAL BETWEEN ONSET AND DEATH 1 min. Years Years														
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)														
21 I certify that (x) (this hospital) attended the deceased from 6-30 1958 to 9-9 1960, that (x) (we) last saw the deceased alive on 9-9 1960, and that death occurred at 11:25P from the causes and on the date stated above														
22a. SIGNATURE Albert L. Mooney, M.D.					22b. DATE SIGNED 9-10-60									
22c. PHYSICIAN'S NAME (Type) Albert Mooney, M.D.					22d. ADDRESS VAH, Perry Point, Md.									
23a. BURIAL, CREMATION, or other disposition Burial & removal			23b. DATE THEREOF 9-11-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town, or county) (State) Ft. Myers, Va.						
24. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS,					25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE James L. Howard							

CERTIFICATE OF DEATH

Reg. Dist. No.

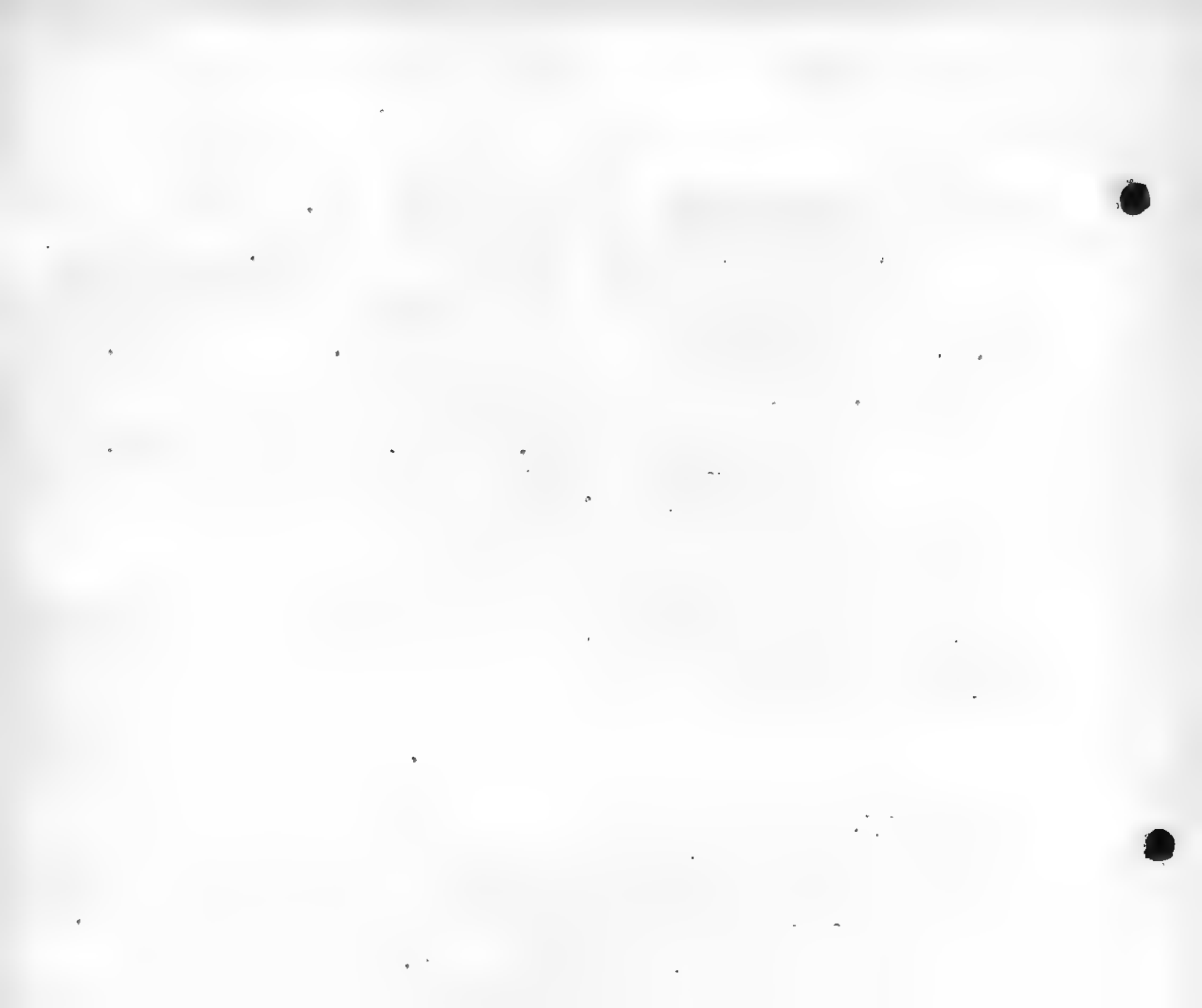
10166

10184

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				d. STREET ADDRESS 100 Elkton Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle WINFIELD Last LEWIS				4. DATE OF DEATH Month Sept. Day 26 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1872	
9. AGE (In years last birthday) 88 yrs		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min.		IF UNDER 24 HRS Months 88 Days 88 Hours 88 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Public Service Clerk				10b. KIND OF BUSINESS OR INDUSTRY Elkton, Md.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles E. Lewis				14. MOTHER'S MAIDEN NAME Martha Maxwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Dewey Patterson, Elkton, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis (c) Coronary atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 16 , 19 60 , to Sept 26 , 19 60 , that I last saw the deceased alive on Sept 26 , 19 60 , and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED 9/26/60 ACTUAL SIGNATURE Henry D. Davis M.D. Chesapeake Bay Md PHYSICIAN'S NAME (Type) HENRY V.D. DAVIS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-60		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME Donald H. Lee				24a. REC'D BY REGISTRAR MD SEP 29 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10185

CERTIFICATE OF DEATH

10167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Elkton Hospital		d. STREET ADDRESS Barksdale Road. R.F.D.	
3. NAME OF DECEASED (Type or print) Ella First H. Middle Musser Last		4. DATE OF DEATH Month 9 Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1878.
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Rockey		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO INFORMANT	
17. ADDRESS Delaware.		18. ADDRESS Roy Musser. 20 S. Old Baltimore Pike. Christiana.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractures right hip DUE TO Fall at home Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Paralysis left DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8/24/60 8/26/60	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis left		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fall at home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9/20 1960 6:30 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20 1960 to 9/19 1960 , that I last saw the deceased alive on 9/19 1960 , and that death occurred at 6:30 p.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cherry Hill Maryland DATE SIGNED 9/19/60	
ACTUAL SIGNATURE Henry V. Davis M.D.		PHYSICIAN'S NAME (Type) HENRY V. DAVIS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-22-60.	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cherry Hill Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR SEP 23 1960 24b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



10186

CERTIFICATE OF DEATH

Reg. Dist. No. 10168

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East			
				f. STREET ADDRESS			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Calvin Parsons				4. DATE OF DEATH Month Sept. Day 4 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1894	
				9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Prov. Gr.			
				11. BIRTHPLACE (State or foreign country) Del Mar, Delaware			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Cal Parsons				14. MOTHER'S MAIDEN NAME Ella Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-13-1133			
				17. INFORMANT Address Mrs. Susie Parsons, North East, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Carcinoma of Prostate							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 22, 1960, to Sept 4, 1960, that I last saw the deceased alive on Sept 4, 1960, and that death occurred at 10:30 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Davis MD				ADDRESS (Street, city or town, state) DATE SIGNED CHESAPEAKE CITY 11/10/60			
PHYSICIAN'S NAME (Type) Henry V. Davis MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-7-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Baptist Cemetery		22d. LOCATION (City, town, or county) (State) North East Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant				24a. REC'D BY REGISTRAR DATE SEP 7 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10187

CERTIFICATE OF DEATH

Reg. Dist. No.

10170

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena 14X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Mollie Middle E. Last Petticord				4. DATE OF DEATH Month September Day 25 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 20, 1869		9. AGE (In years last birthday) 91 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lewis Hayes				14. MOTHER'S MAIDEN NAME Sarah Appleby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Miss, Selma Scotten,		Address Galena, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Nephrosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far-advanced senility							
INTERVAL BETWEEN ONSET AND DEATH 3 weeks. years. years.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 1960, to Sept. 25 , 1960 that I lost the deceased on Sept. 25 , 1960, and that death occurred at 6:00 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Wallace Obenshain, M.D. 27 Sept 60							
ACTUAL SIGNATURE Wallace Obenshain, M.D. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. Cecilton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 28, 1960		22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		22d. LOCATION (City, town, or county) (State) Galena, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows				24a. REC'D BY REGISTRAR DATE SEP 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10171

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge c. LENGTH OF STAY IN b. 11 hrs 45 min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNTC, Bainbridge, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit d. STREET ADDRESS 203-B Laffey Circle, Manor Heights e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS CHARLES PORTER 4. DATE OF DEATH September 15 1960 5. SEX Male 6. COLOR OR RACE Caucasian 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 7-3-59 9. AGE (In years last birthday) 1 yrs. 1 month 1 day 1 hour 1 min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) VIRGINIA 12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME RICHARD WINFIELD PORTER 14. MOTHER'S MAIDEN NAME LINDA MAE LACY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 100-1-100000 17. INFORMANT Hospital Records Address Station Hospital, USNTC, Bainbridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumococccic Meningitis 340.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 35 hr. 45 min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. _____ p.m. _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED _____ Address (Street, city, town, or county) _____	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial 22b. DATE THEREOF 9-17-1960 22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cemetery, Coloma, Md. 22d. LOCATION (City, town, or country) (State) Perryville, Md.		23. FUNERAL DIRECTOR Lee a. Patterson, Son ADDRESS Perryville, Md. 24a. REC'D BY REGISTRAR SEP 19 '60 24b. REGISTRAR'S SIGNATURE Arthur S. House	

100



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1020

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10172

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton R.D.</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton R.D.</u> d. STREET ADDRESS <u>Dogwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence Powers</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>19 60</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>37</u> yrs. 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> 11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Repairing autos</u> 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Powers</u> 14. MOTHER'S MAIDEN NAME <u>Emma Ball</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>238-30-5342</u> 17. INFORMANT <u>Mrs. Clarence Powers, Elkton, Md.</u> Address <u>R.D.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbon Monoxide gas poisoning</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Attached hose to exhaust pipe and ran hose into car</u> 20c. TIME OF INJURY Month, Day, Year <u>9/21 19 60</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u> 20f. (City or town) <u>Elkton</u> (County) <u>Cecil</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>R. C. Dodson</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>9/24/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u> 22d. LOCATION (City, town, or county) <u>Cherry Hill, Cecil, Md.</u>		23. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> ADDRESS <u>Elkton, Md.</u> 24a. REC'D BY REGISTRAR <u>OCT 10 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10188

CERTIFICATE OF DEATH

Reg. Dist. No.

10173

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN TB 6 days Warwick,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. STREET ADDRESS 1 Golts Rd.			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Raison				4. DATE OF DEATH Month Day Year Sept 17 19 60			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/26	9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well digger		10b. KIND OF BUSINESS OR INDUSTRY plumbing		11. BIRTHPLACE (State or foreign country) Concord Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Otto Raison				14. MOTHER'S MAIDEN NAME Viola Hinson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. (If you give war or dates of service) W.W.11 218-20-3519		INFORMANT Viola Hinson Address Warwick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous meningitis DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c) 9 months							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from Sept 11 , 1960, to Sept 17 , 1960; that I last saw the deceased alive on Sept 17 , 1960, and that death occurred at 10:30 AM from the causes and on the date stated above.							DATE SIGNED 21 Sept
ACTUAL SIGNATURE Wallace Obenshain M.D.		ADDRESS (Street, city or town, state)					
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.		Cecilton, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/24/60	22c. NAME OF CEMETERY OR CREMATORY Bohemia Manor Cem.	22d. LOCATION (City, town, or county) (State) Bohemia Manor, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Ed R Bell ADDRESS 909 Poplar St.			24a. REC'D BY REGISTRAR SEP 26 '60	24b. REGISTRAR'S SIGNATURE W. S. Hume			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10174

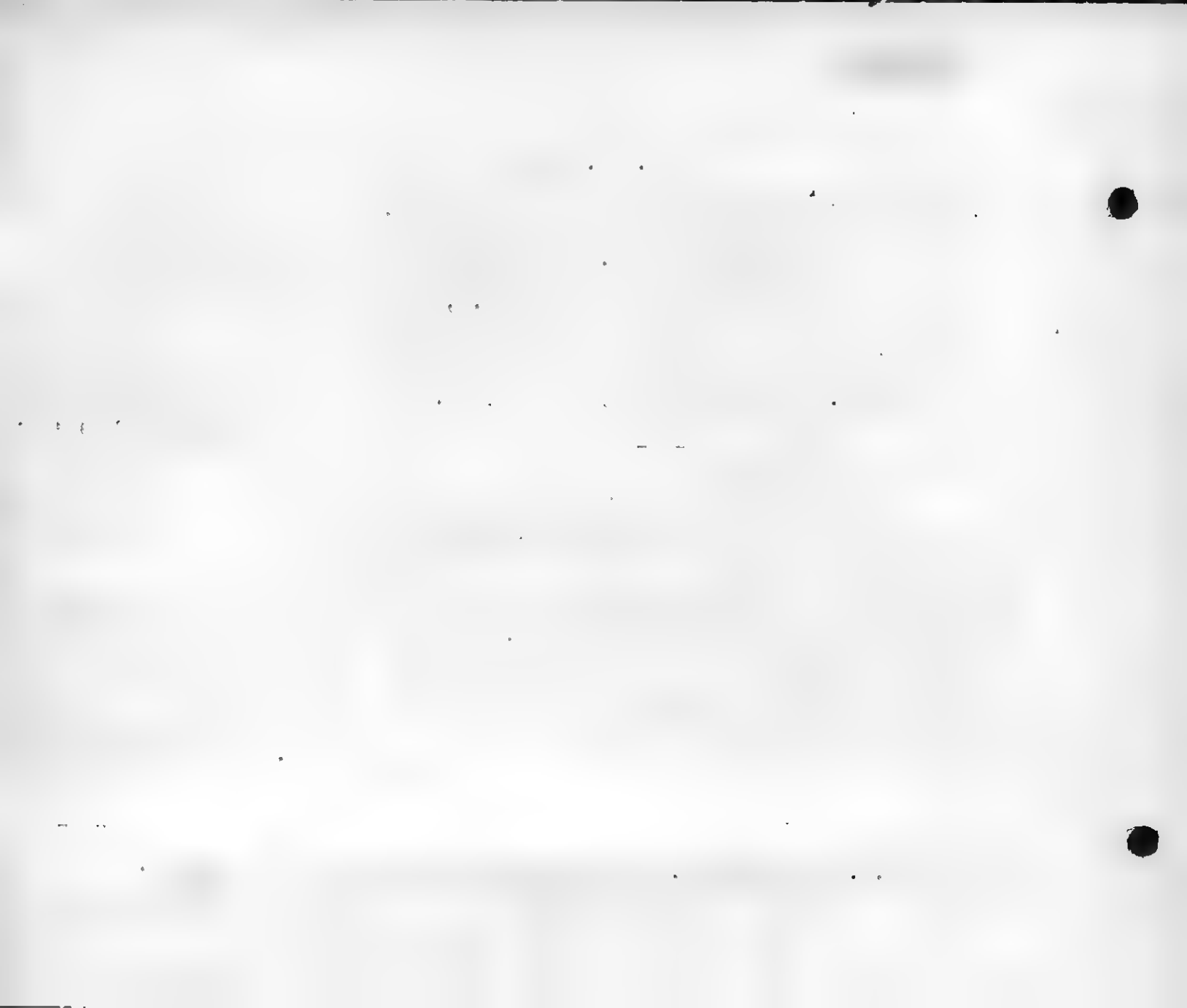
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 36 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Cecil Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Philip Middle Richard Last Ricards				4. DATE OF DEATH Month Sept. Day 16 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Tea Room Gas Station		11. BIRTHPLACE (State or foreign country) Bay View, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip A. Ricards				14. MOTHER'S MAIDEN NAME Martha Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Philip R. Ricards, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of prostate with metastasis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15, 1955, to 16 Sept. 1960, that I last saw the deceased alive on 15 Sept. 1960, and that death occurred at 1:50 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huebner		M.D.		ADDRESS (Street, city or town, state) North East, Md.		DATE SIGNED 9/16/60	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-60		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) (State) North East Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR DATE SEP 21 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

10206

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10175

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 4yrs.5mo.19days		d. STREET ADDRESS 26th E. Franklin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Omar Middle D. Last ROUZEE		4. DATE OF DEATH Month September Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1897
9. AGE (in years last birthday) 63 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Rouzee (deceased)		14. MOTHER'S MAIDEN NAME Mary E. Fisher (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes WW I		16. SOCIAL SECURITY NO 219-20-4407	
17. INFORMANT Address: Charlestown, W. Va. Russell Rouzee, Brother, S. Prospect Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, retroperitoneal from aortic synthetic graft DUE TO (b) Arteriosclerotic aortic aneurysm DUE TO (c) Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Myocardial infarction, posterior wall			INTERVAL BETWEEN ONSET AND DEATH 28 hours unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXX attended the deceased from April 10, 1966, to Sept. 29, 1960, and that death occurred at 8:50 pm from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 9-30-60	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. B. IS REMOVAL (Specify)	23b. DATE THEREOF 10/1/60	23c. NAME OF CEMETERY OR CREMATORY Pope John	23d. LOCATION (City, town, or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Funerary Co. Hagerstown Md.		25. REC'D BY REGISTRAR DATE OCT 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



CERTIFICATE OF DEATH

Reg. Dist. No.

10176

10189

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN TB 54 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.		e. STREET ADDRESS Elk Mills	
3. NAME OF DECEASED (Type or print) First Elmer Middle V. Last Ruth Sr.		4. DATE OF DEATH Month Sept. Day 14 Year 1960	
5. SEX M	6. COLOR OR RACE Cav	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/1886
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Worker		10b. KIND OF BUSINESS OR INDUSTRY Textiles	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Allen Roth		14. MOTHER'S MAIDEN NAME Emma IRONS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-8854	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Anemia & Malnutrition DUE TO Intestinal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cancer of Stomach DUE TO (c) 1 yr.		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 9 , 19 60 , to Sept 14 , 19 60 , that I last saw the deceased alive on Sept 14 , 19 60 , and that death occurred at 9:30 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 225 W. Main St DATE SIGNED 9/14/60			
ACTUAL SIGNATURE Joseph S. Janzi M.D.		PHYSICIAN'S NAME (Type) Joseph S. Janzi Elkton Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-18-60	22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk. Nr. Elkton, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME ADDRESS Donald H. Dee Elkton, Md.		24a. REC'D BY REGISTRAR SEP 20 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thoma

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10190

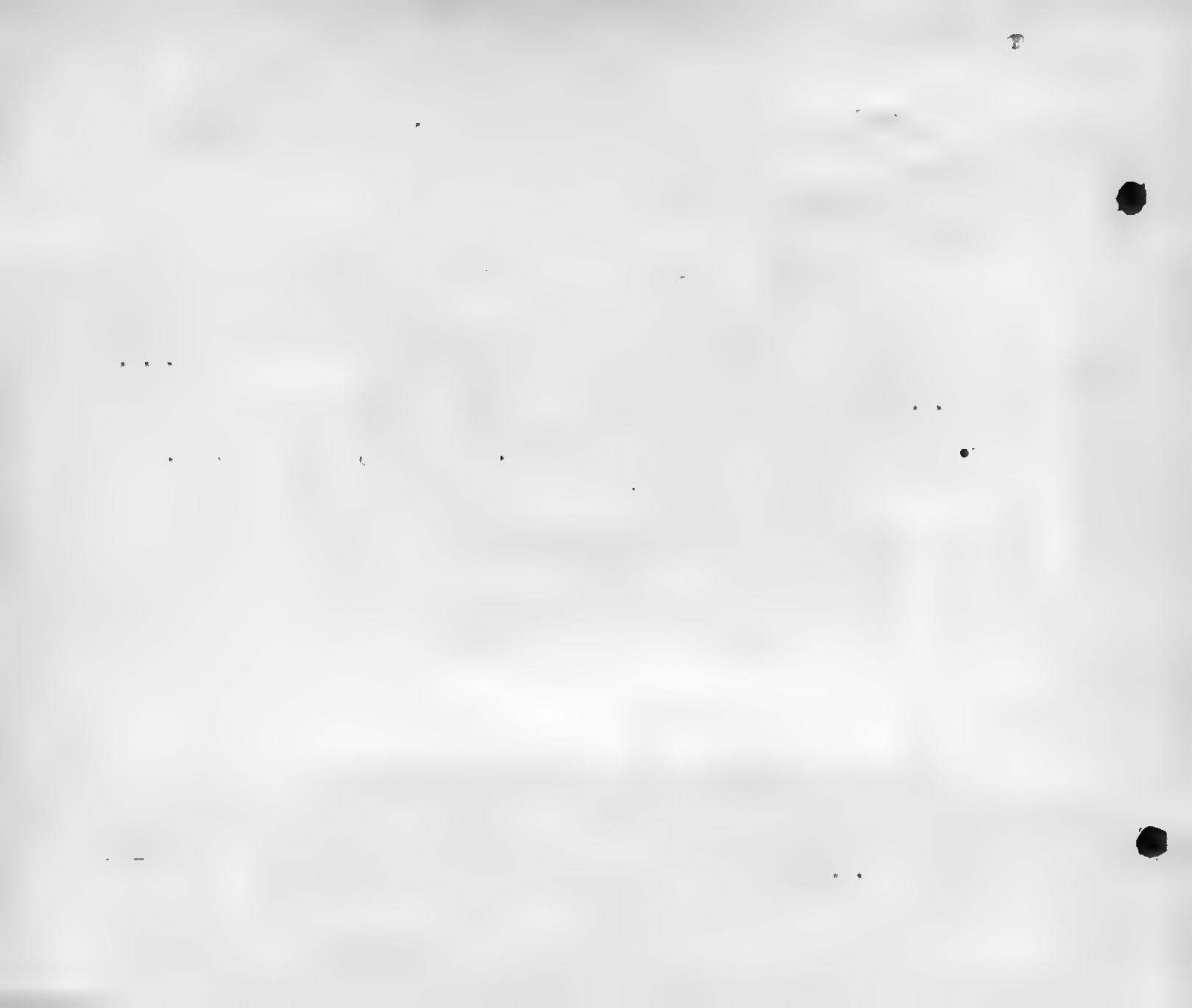
10177

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN b 1 hour			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS North East			
3. NAME OF DECEASED (Type or print) First Edna Middle H Last Ryan				4. DATE OF DEATH Month 9 Day 15 Year 1960			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 28, 1901	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 15 Hours 19 Min. 60		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY House-Keeping			
13. FATHER'S NAME F.G. Harvey				14. MOTHER'S MAIDEN NAME Laura Grant			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 216-16-4726			
17. INFORMANT Mr. John Ryan, North East, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hemiplegia							
DUE TO (b) Arterio-sclerosis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson				DATE SIGNED 9-16-60			
EXAMINER'S NAME (Type) R.C. Dodson				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-1960		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or country) (State) North East, Cecil Co., Maryland	
23. FUNERAL DIRECTOR Joseph R. Grant				24a. REC'D BY REGISTRAR SEP 20 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss							



10191

CERTIFICATE OF DEATH

Reg. Dist. No.

10178

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>W. SCARBOROUGH</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Talbort Scarborough</u>				14. MOTHER'S MAIDEN NAME <u>Jane Witworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>214-01-0808</u>		INFORMANT Address <u>John F. Stephens, Elkton, Md. R.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION/THROMBOSIS</u> DUE TO (b) <u>CORONARY HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Shown?</u> <u>Symptoms?</u> <u>Diagnosis??</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. <u> </u> Day. <u> </u> Year <u>19</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/4</u> , 19 <u>60</u> , to <u>9/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>60</u> , and that death occurred at <u>5:47 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>9/4/60</u> ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D. PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cherry Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10192

CERTIFICATE OF DEATH

Reg. Dist. No.

10179

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Daisy Middle Smith Last Smith				4. DATE OF DEATH Month September Day 26 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September, 23, 1880		9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months 3 Days 12	IF UNDER 24 HRS Hours 3 Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Templeton				14. MOTHER'S MAIDEN NAME Mary Elizabeth Knotts.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Name Walter Smith, Address Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO 550-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemic heart disease DUE TO Ruptured aorta (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 1/2 months 3 1/2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic arthritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1960 to Sept 26, 1960 , that I last saw the deceased alive on Sept 26, 1960 , and that death occurred at 8:00 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Henry V. Davis M.D.				ADDRESS (Street, city or town, state) Chesapeake City, Md. DATE SIGNED Sept 26, 1960			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 29, 1960		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward F. Fickens				ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS, A15ME
SM 7/59

113
FOR STATE
HEALTH DEPT.

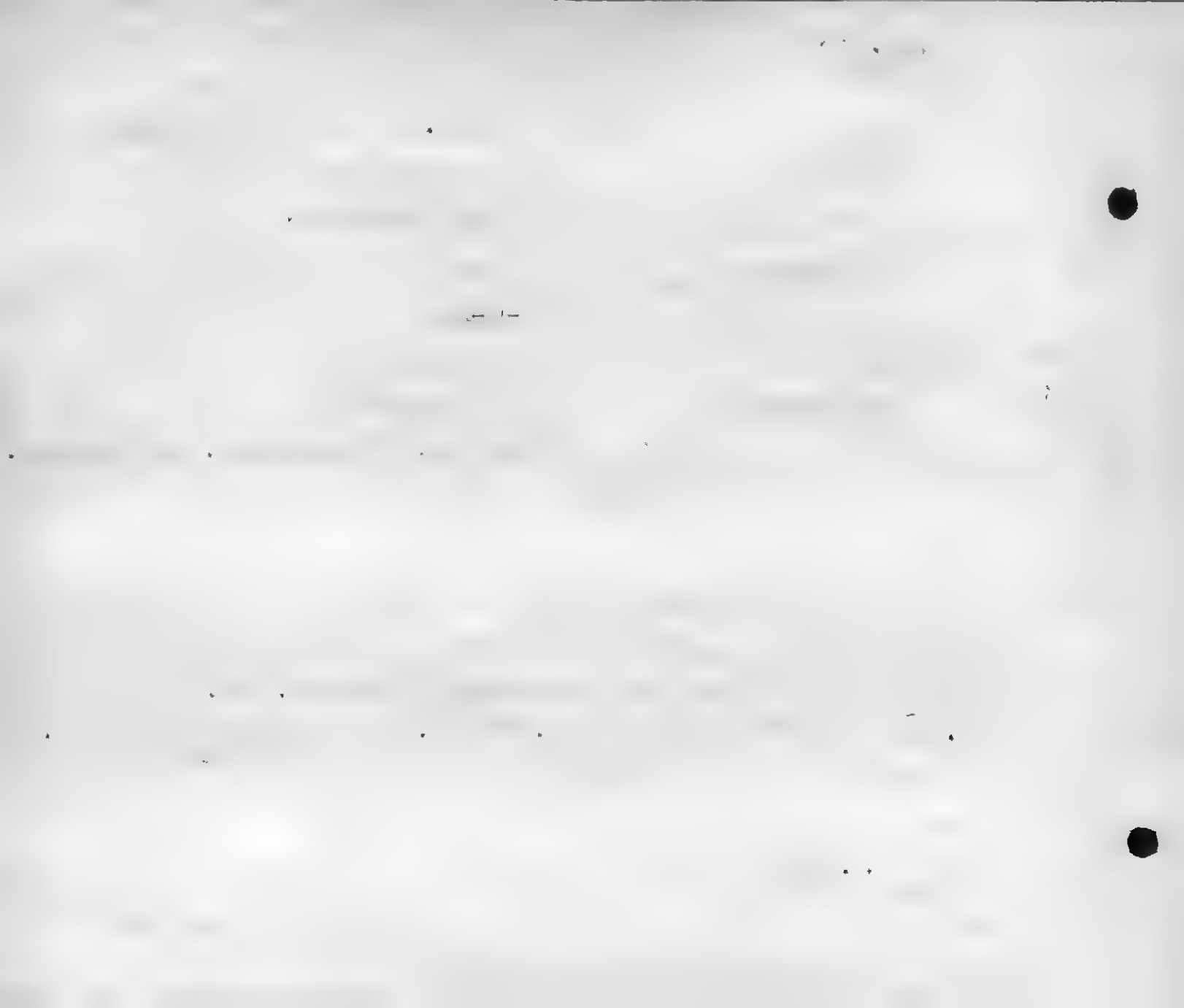
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10180

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Del. b. COUNTY New Castle	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wilmington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS 600 Vandeder Ave.	
3. NAME OF DECEASED (Type or print) Elizabeth		4. DATE OF DEATH 9 18 1960	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-1912	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME no information		14. MOTHER'S MAIDEN NAME no information	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no information	
17. INFORMANT no information		Address Diame Tor, 600 Vandeder Ave. Wilmington, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Drowned 850X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Power boat hit by a Tanker in Canal Ches. & Del.	
20c. TIME OF INJURY Month, Day, Year 8.50 a.m. 9 18 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Del. and Ches. Cal Chesapeake City Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-60	
22c. NAME OF CEMETERY OR CREMATORY All Saints		22d. LOCATION (City, town, or country) (State) Wilmington New Castle Del	
23. FUNERAL DIRECTOR Joseph R. Grant North East, Md.		24a. REC'D BY REGISTRAR SEP 21 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10181

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DEL. b. COUNTY N. CASTLE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE CITY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILMINGTON	
c. LENGTH OF STAY IN b. 1 DAY		d. STREET ADDRESS 600 VANDEVER ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH A. TOR		4. DATE OF DEATH Month SEPT Day 18 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1912
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 4 Days 7	
11. IF UNDER 24 HRS. Hours 4 Min. 7		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE		10b. KIND OF BUSINESS OR INDUSTRY SALES	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No INFO		14. MOTHER'S MAIDEN NAME No INFO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT MRS. JAMES PICCIOTTI WILM, DEL.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 750X Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CRUISER HIT BY OIL TANKER	
20c. TIME OF INJURY Month, Day, Year 8:50 a.m. 9-18-60		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) C+D CANAL CHESAPEAKE CITY, MD.	
20e. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE R.C. DODSON		M.D.	
EXAMINER'S NAME (Type) R.C. DODSON		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-24-60	
22c. NAME OF CEMETERY OR CREMATORY ALL SAINTS		22d. LOCATION (City, town, or country) (State) WILM, DEL.	
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR SEP 26 '60	
ADDRESS ELKTON, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10207
CERTIFICATE OF DEATH

10182

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harpur	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 1231.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 36 Monroe	
3. NAME OF DECEASED (Type or print) First JACK , Middle JOHN (XXXX) Last W. WILLIS		4. DATE OF DEATH Month September Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-5-98
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas Willis(deceased)	
14. MOTHER'S MAIDEN NAME Josephine Morris		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. 577-12-4554		17. INFORMANT Address Aberdeen, Md. Mrs. Elsie Ames, sister, 36 Monroe Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Auricular Fibrillation (Clinical) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Central vascular hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized			INTERVAL BETWEEN ONSET AND DEATH unknown unknown unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that xx (this hospital) attended the deceased from September 9, 1960 to September 18, 1960 and that death occurred at 4:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney		22b. DATE SIGNED 9-19-60	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.		22d. ADDRESS Swan Creek, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/21/60	23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cemetery	23d. LOCATION (City, town, or county) (State) Swan Creek, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Tarrin		25a. REC'D BY REGISTRAR SEP 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass		25c. REGISTRAR'S NAME Arthur S. Kneass	

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10193 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

10183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
c. LENGTH OF STAY IN 1b 14 hrs.				d. STREET ADDRESS Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BERTHA Middle F. WOOLMAN Last				4. DATE OF DEATH Month Sept. Day 11, Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Elkton, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Emanuel Major				14. MOTHER'S MAIDEN NAME Emma line Roff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Mrs. Mildred Cameron, R. D. Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Vent Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) AKD, Chronic Bronchitis							INTERVAL BETWEEN ONSET AND DEATH 2-3 hours 2-3 days 3 weeks?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/10 , 19 60 , to 9/11/60 , 19 60 , that I last saw the deceased alive on 9/11/60 , 19 60 , and that death occurred at 5:45 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 154 W Main DATE SIGNED 9/11/60							
ACTUAL SIGNATURE Peter Stavrakis				M.D. 154 W Main			
PHYSICIAN'S NAME (Type) PETER STAVRAKIS				ELKTON, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-14-60		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Donahue, Elkton, Md		24a. REC'D BY REGISTRAR SEP 20 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

MEDICAL CERTIFICATION

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